TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN AND RECOVERY CLINIC

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-17-3676-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After numerous conversations with several individuals at CCMSI, including a supervisor, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized."

Amount in Dispute: $14,404.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 25, 2017. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2010 through March 28, 2012	97110-GP, 97140-GP, 97032-GP, 97112-GP and 97799-CP	$14,404.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim lacks information which is needed for adjudication
   - 295 – We cannot review this service without the report or invoice
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 1240 – Payment disallowed reimbursement decision previously rendered

- 309 – The charge for this procedure exceeds the fee schedule allowance
- P12 – Workers Compensation jurisdictional fee schedule adjustment
- 119 – Benefit maximum for this time period or occurrence has been reached
- 168 – billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
- 309 – Charge for this procedure exceeds the fee schedule allowance
- W1 – Workers compensation state fee schedule adjustment
- 886 – The procedure was inappropriately billed. The provider has previously billed for an initial/evaluation visit.
- B16 – Payment adjusted because ne patient qualifications were not met

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The dates of the service in dispute are November 15, 2010 through March 28, 2012. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 17, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B), although the requestor refers to a Decision and Order issued in 2011, the EOBs submitted with the DWC060 do not contain denial reasons for (CEL) Compensability, Extent of Injury and or Liability. The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.
A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.
The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.